diet. A large haematemesis of 2 pints (1.1 litre) occurred 7 days later. A blood transfusion was given on usual indications and improvement followed only to be punctuated by another haematemesis. Investigations included test meal, which indicated high total acid. Radiography demonstrated an ulcer on lesser curve and a duodenal ulcer. Progress uneventful.

(2) A housewife aged 58 admitted on history of 7 days' weakness, melaena, and recent haematemesis. Past history pointed to symptoms of gastric ulcer dating from 1933. She had small repeated haematemeses, and response to transfusion was good. Radiography revealed two gastric ulcers. She was discharged in due course.

(3) A woman aged 70 was admitted as an "acute abdomen." Past history yielded vague dyspeptic symptoms culminating in an attack of upper abdominal pain associated with vomiting of two days' duration. Abdominal section showed blood-stained fluid and early peritonitis. On inspection of stomach a large prepyloric perforation below lesser curve was noted. Induration was a feature. On opening lesser sac a gastric mass posteriorly was attached to pancreas without obvious signs of malignancy. On separation, a larger ulcer presented. Ulcers were closed. Histological examination demonstrated chronic ulceration and ruled out neoplastic change. Condition on discharge was satisfactory.

(4) A middle-aged Chinese man was admitted with a diagnosis of pulmonary tuberculosis and died from this malady. At necropsy two chronic ulcers were found on lesser curve about 1 in. (2.5 cm.) apart.

(5) A man aged 69 was admitted with vague abdominal pain occurring mainly after meals, of several years' duration. Radiography one year previously had yielded negative results. Three days later he vomited three-quarters of a pint (430 ml.) of "coffee grounds" fluid. In spite of blood transfusion and other supporting measures he deteriorated rapidly and died. Necropsy findings—(*a*) Oesophagus: dilatation of lower end, with ulcer 3 cm. by 2 cm. immediately above ridge separating oesophagus from stomach. Base indurated and adherent to left lung. Floor of ulcer presented several small oozing points. (*b*) Stomach: ulcer 2.5 cm. by 2 cm. immediately distal to gastro-oesophageal ridge. Floor smooth and fibrotic.

This group of five cases is drawn from an ulcer case list numbering 100 per year approximately. The lesions were demonstrated radiographically (two), post mortem (two), and one at operation.—We are, etc.,

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## Amoebiasis

SIR,—Correspondence on amoebiasis must come to you with a considerable time-lag, as those who contribute are usually remotely situated. Dr. M. L. Mason's letter (Aug. 31, p. 308) is eminently practical, and stresses aspects which are too often left unstressed and which are so important that I hope colleagues at home, unused to many peculiarities which the condition is apt to exhibit, will take his letter as a timely warning. The infective stage of the amoeba being the cyst adapted to withstand adverse conditions such as drought, gastric juice, etc., cyst-passers reaching the U.K. are liable to start the disease in its most active form over wide areas. Where rural sanitation still exists, this may be more than a possibility; where water sanitation obtains, there is no use expecting cysts to perish due to the anaerobic action of septic tanks and sewage systems; and there is always the house-fly. There is also the carrier who can infect food; I have often examined matter removed from under finger-nails and found cysts present. In view of the fact that the efficacy of treatment of amoebiasis still leaves much to be desired, even treated cases will have to be considered as potential carriers.

To comment on Dr. Mason's typing of symptomatology, I would say that diarrhoea is far from common, and may often be so slight that it is not remembered when, long afterwards, the patient shows symptoms suggesting chronic appendicitis or peptic ulcer. This type is very common, but I do feel that type 4, i.e., the malaise and irritability type, is by far the most frequent. Unfortunately, even if numerous specimens are examined, the stools are usually negative. This is probably because the amoeba is a commensal for quite lengthy periods, and has no need to encyst and find a new host. These negative results may mislead the inexperienced; also the repetition of tests takes up much time, whereas early diagnosis would enable the practitioner to notify his M.O.H. at least a week earlier, even supposing he were lucky enough to find one stool positive by ordinary straight examination. A practice of mine for the last eighteen years has been to give such cases one injection of 1/2 to 1 gr. (32 to 65 mg.) emetine, and examine the stools next morning. I have rarely failed to find cysts when this has been done. They are usually with only one or two nuclei, in other words, finding a new host in a hurry. The reason, of course, is elementary zoology—when conditions become unfavourable (for instance, due to emetine) cysts are formed and pass out to seek a more accommodating host. This provocative test is particularly useful in the chronic patient, whose stools will otherwise always be negative.—I am, etc.,

Arua, Uganda. A. FORBES BROWN.

## "Analgesic" or "Anaesthetic"?

SIR,—Dr. J. N. Fell (Nov. 9, p. 711) objects to the use of the "ugly term analgesic," and while it is obvious that a distinction exists it is only one of degree. The term "analgesic" implies the loss of pain sensations only and "anaesthetic" the loss of all sensations. But I have found that there is an important difference. If chloroform is dropped continually on a mask over the mouth and nose of the patient, sensation of pain is very quickly lost, long before loss of consciousness, and it is well known that hearing may remain quite acute for a considerable time and the anaesthetist has to be careful not to discuss the patient's symptoms until anaesthesia is complete. While analgesia is rapidly produced, the auditory sense is the last to go. The object of the surgeon should be not only curative, but also the complete abolition of any pain. For instance, the removal of a gauze packing in an abdominal wound will cause very acute though temporary pain, which could be completely avoided by producing analgesia by dropping chloroform on a mask continually for one minute only. It was my custom to tell the patient that he or she would be quite aware of the withdrawal of the gauze packing but it would be quite painless, and it became my custom to go round the ward with a mask and a bottle of chloroform. The patient had absolutely no pain and no other symptoms of any kind. In one case a friend of mine whom I visited in the hospital had double pneumonia and was very seriously ill. He told me he had a raging toothache but was refused any anaesthetic owing to his condition. I gave him chloroform for one minute and then extracted the tooth quite painlessly.—I am, etc.,

Worthing. HERBERT H. BROWN.

## Definition of Health

SIR,—I should like to endorse Dr. W. F. Felton's pertinent remarks (Oct. 19, p. 591) concerning the definition of health adopted by the World Health Organization. I have long believed that much confusion of thought and inadequacy of practice, especially in the realm of "social medicine," can be traced to the vagueness of our conception of health. I have pointed out elsewhere (*Medical Officer*, 1946, Mar. 30, p. 118) that in common speech we use "health" indiscriminately, both to refer to a specific ascertainable condition (e.g., he recovered his health) and also as though it were practically synonymous with "condition" itself. If the first is used it is by no means illogical to oppose health and disease, and to define each as the absence of the other. I therefore suggested that we should accustom ourselves to the wider use. This demands a qualifying adjective before it can be applied to particular cases (as good health, better health, indifferent health), and so the true antithesis of "good health" and "bad health" emerges. Disease is relegated to its proper place, which is that of one factor, a very variable one, in particular cases of poor health. Thus a mere grammatical exploration of the term does seem to me notably to clarify our thinking. May I add my own definition of health, which is, in its simplest form, "the total condition of the personality." This provides for the dynamic quality which Dr. Felton so rightly wishes to emphasize. Our aim would be that each individual might continually approach his "best possible" total condition. In this way, goal can move constantly ahead of achievement, and a real constructive "positive" outlook is assured.—I am, etc.,

Gravesend. HERBERT S. DAVIES.